Community cancer programs as strategic alliances: challenges and guidelines for action

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This paper assesses the utility of strategic alliances as a way of expanding and improving the quality of cancer care provided in communities with limited access to major treatment centres. Alliances provide an organizational model for future community-based cancer programs by accommodating a growing need for interdependence among organizations and providers while permitting substantial independence and autonomy. Five managerial challenges to ensuring effective and efficient delivery of cancer services are identified: to secure mutually reinforcing exchanges between and within all levels of cancer care, to develop protocols and programs relevant to the unique characteristics of patients and providers, to provide treatment and cancer control services, to involve interdisciplinary teams of providers at all levels of care and to achieve quality assurance, improvement and evaluation. In addition, the paper includes a set of guidelines to facilitate the implementation of community cancer programs as strategic alliances: reaffirm the role of community oncologists, primary care physicians and nurses as partners in the program; define the structure and culture necessary for commitment rather than simply compliance; redefine the role of management; establish data-monitoring systems; modify reward systems; and set realistic time frames and expectations.

Cette communication analyse l'utilité d'alliances stratégiques comme moyen d'élargir et d'améliorer la qualité des services de cancérologie fournis dans les localités qui ont un accès limité aux grands centres de traitement. Les alliances offrent un modèle organisationnel de futurs programmes communautaires de cancérologie en tenant compte d'un besoin croissant d'interdépendance entre les organisations et les pourvoyeurs tout en permettant une indépendance et une autonomie considérables. On identifie cinq défis administratifs qu'il faut relever pour assurer la prestation efficace et efficiente de services de cancérologie : établir des échanges qui se renforçent mutuellement entre tous les niveaux de soins en cancérologie et à l'intérieur de chacun d'eux, établir des protocoles et des programmes pertinents aux caractéristiques particulières des malades et des pourvoyeurs de soins, fournir des services de traitement et de lutte contre le cancer, faire intervenir des équipes interdisciplinaires de pourvoyeurs de soins à tous les niveaux et assurer des services de contrôle de la qualité, d'amélioration et d'évaluation. La communication comprend de plus une série de lignes directrices destinées à faciliter la mise en oeuvre de programmes communautaires de cancérologie

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en tant qu'alliances stratégiques : réaffirmer le rôle des cancérologues communautaires, des médecins de soins primaires et des infirmières en tant que partenaires du programme; définir la structure et la culture nécessaires pour obtenir un engagement plutôt qu'une simple observation; redéfinir le rôle de la direction; établir des systèmes de contrôle des données; modifier les systèmes de récompense; et établir des délais et des attentes réalistes.

The urgent and complex issues associated with cancer care are seriously testing the ability of health service organizations and providers to deliver high-quality, efficient care. Although there are various outreach and affiliate organizations[1] the difficulty in providing not only state-of-the-art therapy but also early detection and control regimens to underserviced and rural populations in Canada is the main challenge facing cancer agencies today.

The unrelenting demands of increasing costs and expanding technology and the continuous need to improve quality are directing attention to organizational forms other than conventional regionalized programs, such as strategic alliances. These alliances are broadly defined as loosely connected groups of existing organizations and providers established for a long-term strategic purpose not attainable by one participant alone.[2] This paper assesses the utility of strategic alliances in providing cancer care to underserviced and rural populations and suggests guidelines for implementation.

Challenges facing community cancer programs

Strategic alliances provide a model for community-based cancer programs by accommodating the growing need for interdependence among organizations and providers while permitting them substantial independence and autonomy. Although the exact form will vary from province to province alliances among researchers, planners and providers can expand existing models of cancer care and improve the quality of care provided in communities with limited access to major treatment centres. Through this mechanism there would be an integrated network of services and social relations at the provincial, regional and community levels. These arrangements challenge conventional managerial approaches and thus require special attention to the interaction between and within participating bodies. The objective is to design and manage a network that "links experts with non-experts in order to diffuse information in 'state-of-the-art' care."[3] The people involved, the prevailing informal relations and norms, the substance of the activity, the information available and the way in which information is used will all determine how well an alliance enhances the overall quality and efficiency of cancer care at the community level. To be effective and efficient a number of managerial challenges must be met.

- To ensure mutually reinforcing exchanges between and within levels of cancer care.
- To develop protocols and programs relevant to the unique characteristics of patients and providers.
- To provide treatment and cancer control services.
- To involve interdisciplinary teams of providers.
- To achieve quality assurance, improvement and evaluation.

Mutually reinforcing exchanges

The relations between and within the various levels of care require special attention to the flow of resources and information. These relations have an interactive effect over time and are shaped by experiences in working together, mutual adaptation and the institutionalization of transactions and experiences.[4,5] The exchanges that evolve depend on each other in various ways and challenge our ability to manage both the inherently fragile relations within the new organizational alliances and the changes required in the established, participating organizations.[6] Our ability to address the challenges successfully depends on how well management at all levels deals with issues such as commitment, control and the benefits gained over time.

The central philosophy underlying strategic alliances is commitment rather than control. This represents a shift in our way of thinking about organizations in general[7,8] and about the management of interorganizational networks providing cancer care to local communities in particular.[2] In Drucker's view of the "coming of new organizations"[9] we are beginning to see a shift from a command-control structure toward a commitment structure. These new organizations are built on a unified vision of common values and accountability achieved through commitment and shared information, not through coercion and mindless compliance with rules and regulations. Organizations and providers at all levels believe that they are stronger together than apart and that to be successful, members have to work diligently to maintain cohesiveness. Commitment builds over time and ensures the maintenance of the alliance.

A commitment among members of the alliance at all levels of cancer care will be constantly tested. Over time, incentives and pressures will limit participation, thus restricting the full potential of the alliance to provide efficient and effective cancer care. However, the remarkable thing about alliances is that they tend to be long lasting once established. Perhaps a case in point is the Community Clinical Oncology Program (CCOP) of the US National Cancer Institute (NCI).[5,10] This alliance involves groups of physicians and local community hospitals, networks of research bases (e.g., the Eastern Cooperative Oncology Group) and the NCI. The program aims to transfer state-of-the-art technology to local communities through the use of clinical trials in therapy and cancer control research. Local communities are affiliated with various research bases according to the bases' anticipated ability to develop protocols of interest. This is a fragile relation because CCOPs may change their affiliation, depending on the availability of relevant protocols. However, a change in research base creates "switching costs" such as requesting NCI approval, the discovery of a base that can offer a similar array of protocols, the establishment of a reputation in a new base and the ending of personal relationships that have become valued over the years. In Canada the concern is not that local physicians and organizations would form another alliance but that they would decide not to participate substantively once involved in the program; this decision would thus reduce the overall effectiveness of the alliance.

If commitment is the organizing principle around which alliances are formed and sustained, then the notion of "value added" is the criterion against which such commitment will be measured. Organizations and providers at all levels of the alliance must perceive something of value in the exchange other than mere compliance with rules and regulations or the arrangement will likely not survive, given the complexity of providing cancer services. The alliance must be viewed in terms of long-term strategic benefits (tangible or intangible) in the overall provision of cancer care. Providers must consider the costs of participating in the affiliated network.

Alliances can assist participants in several ways: by assuring the timely referral of patients to the appropriate level of care, by assuring the diffusion of up-to-date technologies to local community physicians, by avoiding wasteful duplication of services and equipment within and between levels of care, by providing opportunities for joint research and by ensuring that those in tertiary care facilities know the realities of providing cancer care in local communities.

Protocols and programs

The provision of cancer care to families living in small communities requires explicit recognition, as this population faces a number of significant barriers.[11] Community hospitals do not have medical specialty resources or technical equipment, they have fewer physicians and support personnel per capita than in urban areas, and they have poorly developed transportation systems. Moreover, the rural areas have a greater proportion of elderly and native people, and there is a tendency to seek medical help only for significant symptoms and not for follow-up care. To overcome these barriers patients require special assistance such as transportation and follow-up care by support personnel.

The providers, too, have a number of unique characteristics important to the development of protocols and programs. Rural practitioners are primarily generalists caring for people with a wide variety of diseases. It is unrealistic to expect these physicians to keep up to date with all aspects of cancer care when there are similar demands from other diseases. Although most are apparently willing to participate and carry out follow-up care they need appropriate instruction or education. In British Columbia, for example, a checklist for a follow-up examination of breast cancer provided specific instructions and was found to be very useful; it resulted in the recommendation that follow-up protocols be developed for other cancer sites.[12]

Organizations and providers at different levels have different views of the problems of providing cancer care within the community. What may appear to be a fairly simple and straightforward activity at a tertiary care centre may present major logistic problems at the community level. This is a particularly important issue in the development of cancer control research activities within the NCI-funded CCOP.[13,14] Under this program protocols are developed at research bases for implementation in affiliated CCOPs, but what appears to be simple and advantageous to the research centre often is extremely difficult to implement and has few advantages in the local CCOP. The involvement of community physicians and nurses is critical and helps establish credibility among the participating organizations and providers.[15] As these caregivers take part in activities in larger networks the exchange of information helps in the development of protocols more appropriate to their community.[13]

Treatment and cancer control services

Although there is an emphasis on treatment, early detection and screening in the community is as important. Data from the United States suggest that

physicians generally do not perform early detection activities as often as guidelines recommend[16-18] and that many populations, in particular the poor and minority groups, are underserved.[19-22]

As Greer[23] said, "there are no magic signatories or formats which will cause knowledge to jump off the page and into practice." Moreover, her analysis in the United States and Britain indicated that a physician's decision to adopt new treatments or cancer control regimens is influenced mostly through local communication regarding risk, benefit and appropriateness. She added that "the family doctors show an even more pronounced dependence on local sources of information than do the specialists." Therefore, to provide treatment — particularly cancer control regimens — in the community the complex networks of organizational and interorganizational arrangements that influence physician practice patterns should be recognized.

Interdisciplinary teams of providers

Patients and their families have diverse needs, and to provide the full spectrum of cancer services the program must have access to all relevant disciplines. The role of the primary care physician is crucial. The initial CCOP evaluation,[24] for example, revealed that the inclusion of primary care physicians in local communities was particularly important in ensuring appropriate cancer care. In addition, in our analysis the role of the CCOP nurse and his or her place in the larger network is vital to the CCOP's overall performance, as measured by accrual to treatment protocols.[15] In particular, when nurses attended research base meetings they had an opportunity to become part of a larger network, and thus their sense of involvement and commitment to the program was enhanced. Moreover, the knowledge, skills and commitment of nurses contribute directly to overall success because nurses hold a strategic position between patients and physicians.

Voluntary community groups, also, must be involved in community-based programs, since they provide the community's infrastructure and make it possible to reach patients and their families, particularly for cancer control efforts.

Quality assurance, improvement and evaluation

Although historically attention has been given to quality assurance (i.e., the assessment of program performance against a standard) more attention must be given to quality improvement (i.e., the continual improvement of the whole process of care and not simply the actions of particular professionals). Specifically, we must focus on two aspects of quality: content and delivery.[25] Content quality describes the technical components of care and is primarily evaluated by and based on the expectations of health care professionals. Delivery quality is associated with the interpersonal relationships underlying the delivery of any service and is primarily evaluated by patients and their families.

Both aspects of quality improvement require a paradigm shift in the assessment of program activities. There must be an explicit recognition of the ongoing flow of resources, patients and information within the alliance.[26] The managerial challenge is to reduce variation in this flow. Moreover, if one focuses on the process one can clearly see that there are multiple stakeholders involved in providing cancer care: physicians, nurses and other health care professionals, who evaluate the quality of care content; patients and their families, who evaluate the quality of delivery; health care financiers and regulators, who have expectations regarding content, delivery and costs; and internal customers (e.g., pharmacists, nurses and physicians), who are intermediaries within the alliance. All personnel must participate; in particular a rapid and thoughtful response to suggestions for change is needed from top management. The approach requires rigorous analysis of the process flow, statistical analysis of all activities and the recognition of the underlying psychosocial principles affecting individuals and groups participating in the alliance. Perhaps most critical is the acceptance of the fundamental assumption that many problems result not from errors by professionals or nonprofessionals but, rather, from a failure of the structure.

In addition to quality assurance and improvement a community cancer program as part of a strategic alliance must be evaluated in terms of outcome, with an emphasis on cost-effectiveness. Programs need to demonstrate their effectiveness if they are to compete successfully for limited resources. Thus, the evaluation scheme must involve quantitative and qualitative methods that monitor not only practice patterns and their changes but also a series of organizational and resource indicators associated with such changes. Special attention should be given to basic structural characteristics of the alliance — complexity, centralization of decision-making, and formation of rules and regulations — and to process characteristics — the flow of resources and information and social-political exchange. The underlying culture must be taken into account, as it may influence the overall flow of resources, patients and information and thus facilitate or impede the operations of the alliance.

Guidelines for action

Strategic alliances provide a mechanism that

forces all participants to focus on balancing each other's needs and values rather than simply controlling subordinates. Moreover, they emphasize integration and thus capitalize on the strengths of organizations and providers at all levels of care. What can be done to help implement community cancer programs as strategic alliances?

- Reaffirm the role of the community oncologist, the primary care physician and the community nurse as partners and not subordinates in the program.

Specifically, this requires opportunities for contact on issues of mutual interest. The involvement of community practitioners in a dialogue with regional and provincial personnel about cancer control provides a basis for a true partnership.

The different educational backgrounds, values and interests of researchers, practitioners and others are a constant challenge to the development and maintenance of the cancer program. Yet the provision of cancer care at the community level is truly an interdisciplinary endeavour. Although technical skill is critical there must be an ability to work with and in interdisciplinary groups. The selection of people with technical and social skills is important; however, equally important is the need to provide training in negotiation, conflict resolution and group dynamics.

- Define the structure and culture to emphasize and encourage commitment, not simply compliance.

A community cancer program as an alliance involves contractual relations that operate like hierarchies. These hierarchic elements can include command structures and authority systems (e.g., established lines of communication and quality control systems), incentive systems that measure performance and allocate differential rewards, standard operating procedures and procedures to resolve disputes. The last element is particularly critical given the nature of the alliance; thus, personnel at all levels require special training in conflict resolution.[27] The objective is to convert "win-lose" situations to "win-win" situations and thereby achieve true commitment rather than merely compliance. Various approaches are available. They vary from fairly simple techniques to reduce the level of emotional tension and hostility and enhance accurate communication to more complicated approaches designed to deal with the issue and create new alternatives for agreement on substantive matters.[28] The challenge is to develop and maintain a culture that is supportive and provides a fundamental understanding of the mission and each person's role in it.

- Redefine the role of management.

The management of a strategic alliance resembles more the operation of a sailboat than that of a power boat. The sailboat depends on close teamwork and takes advantage of winds and currents to reach its destination. The power boat requires less teamwork and depends on the power of the machine. Although both are likely to reach their destination the sailboat may prove to be more dependable given rough seas, uncertain weather and the limits of machine technology.

Strategic alliances, like sailboats, depend on teamwork among a loosely connected group of organizations and providers. The role of management is to ensure sufficient flexibility in order to accommodate the various prerogatives and perspectives of the participants while taking advantage of the uncertainties of the larger environment within which the organization operates. Furthermore, there must be integration of managerial and medical activities by people who are able to appreciate the demands of both disciplines.

- Establish data-monitoring systems.

The impact of the activities of the community cancer program and the costs incurred are questions relevant to both internal operations and external authorities. Data systems must be developed that provide this information in a relevant and timely fashion. There is a particular need for studies of practice patterns,[29] which should be population-based rather than facility-based. The cancer site should be selected according to the following criteria: (a) an advance in treatment has been shown to have a positive effect in one or more large-scale trials; (b) the advance is relevant for a significant number of patients; and (c) the advance is perceived as dealing with a problem in clinical practice (e.g., noncompliance with current chemotherapy). These types of studies and the data-monitoring systems required are truly difficult and expensive to implement but are essential to the effective and efficient management of any community cancer program.

- Modify reward systems.

Monetary rewards are only one way to influence behaviour.[30] In health services, characterized by professional status and prerogatives, other currencies need to be used to influence behaviour. For example, the opportunity to be involved in activities that have a greater significance or are simply the "right" thing to do is important. All too often people in organizations think too narrowly and thus limit their ability to influence others.

- Set realistic time frames and expectations.

The process of implementing and institutionalizing a community cancer program as a strategic alliance will take considerable time even under the best of circumstances. At the very least people at all levels of the alliance must start with a realistic estimate of the time required. Two types of time are required: the hours put in by practitioners to launch and maintain the program, and the time needed to

implement the program as an operating network. Both types are important in ensuring the implementation and institutionalization of the program.

Conclusions

How well community cancer programs are implemented will depend on the unique resource requirements and structural characteristics of each province. The National Conference on Community Cancer Programs was a propitious event at which to begin the dialogue necessary to identify complementary strengths and resources and to develop guidelines for implementation. The resultant plan will ensure a program that is responsive to the characteristics of the disease, the patients and the providers.

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